The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Soldiers' Home in Holyoke
110 Cherry Street
Holyoke, MA 01040
(413)532-9475

Soldiers' Home in Holyoke, "Care with Honor and Dignity"
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(please highlight information below and choose print selection, mail completed application to the Soldiers' Home in Holyoke)

SOLDIERS' HOME IN HOLYOKE APPLICATION FOR LONG TERM CARE

DATE:_____

NAME:_____

CURRENT ADDRESS:_____

City/Town:_____ State:_____ Zip:_____

PHONE:_____

SOCIAL SECURITY #:_____

D.O.B:_____

MARITAL STATUS:_____

DO YOU HAVE ANY SERVICE CONNECTED DISABILITIES?_____
IF YES, WHAT PERCENT?_____
WHAT FOR?:_____

YOU HAVE ANY INDUSTRIAL OR AUTOMOBILE ACCIDENT LITIGATION PENDING?_____

HAVE YOU EVER RECEIVED CARE AT THE SOLDIERS' HOME IN HOLYOKE?_____

WHERE IS THE VETERAN NOW?

Home:_____
Hospital:_____
Long Term Care Facility:_____
Date of admission into present facility:_____

LAST PRIVATE RESIDENCE:_____

CURRENT PHYSICIAN:_____

SOCIAL WORKER (IF PRESENTLY IN HOSPITAL OR NURSING HOME):_____

DIAGNOSES:_____

PRIMARY CONTACT PERSON:

Name:_____
Address:_____
City/Town:_____ State:_____ Zip:_____
Home phone:_____ Work:_____ Other:_____

Relationship to veteran:_____

Is the primary contact person also the veterans'
(health care agent), (guardian) or (power of attorney) ? (Please circle all that apply.)

The names of the veteran's parents and their birth places - if known
(even if they are deceased):
_____
_____

If the veteran has GI insurance, the amount it is for:_____
(written proof is NOT necessary for this).

Has the veteran ever had any previous care at any VA facility?
If so, where and when?_____

Please circle: Inpatient Outpatient

What is the veteran's religious denomination (if any)?_____

Who would you like to be the second contact person?

Name:_____
Address:_____
City/Town:_____ State:_____ Zip:_____
Phone: Home:_____ Work:_____ Other:_____
Relationship to the veteran:_____

The third contact person (if any):

Name:_____
Address:_____
City/Town:_____ State:_____ Zip:_____
Phone: Home:_____ Work:_____ Other:_____
Relationship to the veteran:_____

Please provide documentation of:

1.Health Insurance
Medicare card and any other health insurance cards
(please provide us with copies of both sides of all health insurance
cards).

2.Income and assets for both veteran and spouse
-Year 2001 tax return (if filed)
-Proof of gross amounts of Social Security benefits,
pensions and interest income.
-Copies of bank statements for all accounts.
-Proof of all other income and assets (except primary residence)

3.Advance directives which have been executed by the veteran, such as:
-Health Care Proxy*
-Power of Attorney
-Guardianship
-Living Will
-Organ or tissue donation

*This facility recommends that all veterans living at
The Soldiers' Home in Holyoke execute this document.
We can provide you with a blank form if you need one.

To whom shall we send the room and board bill every month? (Guarantor)
Name:_____
Address:_____
City/Town:_____ State:_____ Zip:_____

Phone: Home:_____ Work:_____ Other:_____
Relationship to the Veteran:_____

The following information is only needed if the veterans' gross yearly income minus the last 12 months' worth of medical expenses equals or is below $20,000.00

OR

The veteran already receives a pension from the VA

OR

The veteran has a service connected rating of 50% or greater:

Has the veteran ever filed a worker's compensation claim:

Has the veteran ever applied for or received disability severance pay from the armed forces?
If yes, amount?

Has the veteran received lump sum readjustment or separation pay from the armed forces?
If yes,amount?

Where has the veteran resided for the last three months?
(Please list any hospitalizations and any nursing home type stays)

When did the veteran last work:_____
Who was the veterans' last employer:_____
How long did he/she work there:_____
What was his/her primary occupation:_____

Highest level of education completed:_____

Number of times the veteran has been married:_____

Number of times the veteran's present spouse has been married:_____

Is the veteran's spouse also a veteran?_____

For each marriage of both the veteran and spouse, please answer the following:
(This information is needed even if spouse is deceased)

Date and place of marriage:_____

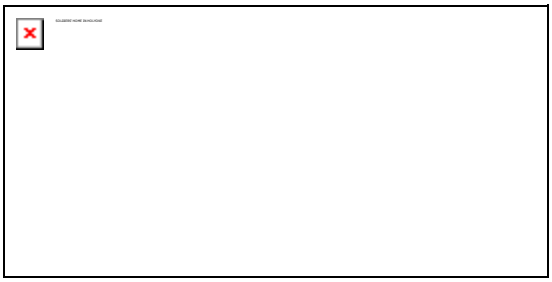
To whom married:_____

How terminated (death/divorce):_____

Date and place terminated:_____

Copy of marriage certificate of current marriage.

"STOP HIGHLIGHTING HERE PLEASE"



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